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in interest, Enrique de Anda Garcia; ENRIQUE DE ANDA GARCIA, individually

**UNITED STATES DISTRICT COURT**  
**FOR THE NORTHERN DISTRICT OF CALIFORNIA**

ESTATE OF ERICK DE ANDA, by	)	<b>CASE NO.</b>
and through successor in interest,	)	
Enrique de Anda Garcia; ENRIQUE	)	<b>COMPLAINT FOR DAMAGES</b>
DE ANDA GARCIA, individually,	)	
	)	1. Failure to Provide Medical Care,
Plaintiffs,	)	Fourteenth Amendment Violation
	)	(42 U.S.C. § 1983)
vs.	)	2. Failure to Protect from Harm,
	)	Fourteenth Amendment Violation
	)	(42 U.S.C. § 1983)
RAYMOND HERR, TAYLOR	)	3. Deprivation of Substantive Due
FITHIAN, KIP HALLMAN,	)	Process, First and Fourteenth
MARIANNE ROWE, ELIZABETH	)	Amendment Violation
FALCON, CINDY WATSON,	)	(42 U.S.C. § 1983)
YVONNE MAXFIELD, JODEL	)	4. Negligent Supervision, Training,
JENCKS, CALIFORNIA FORENSIC	)	Hiring, Retention (County of
MEDICAL GROUP, INC., STEVE	)	Monterey)
BERNAL, JOHN MIHU, JAMES	)	5. Negligent Supervision, Training,
BASS, DAVID COOPER, DAVID	)	Hiring, Retention (CFMG)
RAMON, MONTEREY COUNTY,	)	6. Wrongful Death
MONTEREY COUNTY SHERIFF'S	)	7. State Civil Rights Violation (Cal.
OFFICE, DOES 1-10.	)	Civ. Code § 52.1)
	)	8. Survivorship Action and Request for
Defendants.	)	Punitive Damages
	)	
	)	

**DEMAND FOR JURY TRIAL**

**COMPLAINT FOR DAMAGES**

COME NOW Plaintiffs ESTATE OF ERICK DE ANDA, by and through successor in interest, ENRIQUE DE ANDA GARCIA, and ENRIQUE DE ANDA GARCIA, individually, and allege as follows:

**INTRODUCTION**

1. This civil rights action seeks to establish the true and unequivocal facts surrounding the death of Erick de Anda on September 16, 2015, and to bring to public light the deliberate disregard for public safety carried out by the individual defendants in the present action.

2. This civil rights action further seeks to establish the violations of fundamental rights under the United States Constitution which resulted in the death of Erick de Anda September 16, 2015.

3. Erick was a mentally ill 24-year-old young man, who suffered from suicidal ideations. On September 16, 2015, Erick de Anda committed suicide by hanging himself from a bed sheet in the isolation cell of the Monterey County Jail.

4. Long before Erick de Anda's death, each of the individually named defendants from CFMG and from Monterey County knew that there existed at the Monterey County jail a great suicide hazard to mentally ill inmates. This hazard consisted of a total disregard by jail staff for mentally ill inmates who posed a risk of suicide and inmate cells for mentally ill inmates which contained easy access to hanging points which could be used for suicide.

5. The individuals named in the present lawsuit were repeatedly put on notice of this great hazard to mentally ill inmates through a long history of hanging suicides, through a class-action lawsuit targeting inmate suicide, through warnings from their own experts regarding the suicide risks, through a court order granting a preliminary injunction which directed them to remove hanging points, and through a

6. Despite this long history with inmate suicides, each of the individually names defendants in this lawsuit deliberately failed to take even modest actions to prevent inmate suicides. Thus, by the time Erick de Anda was taken into custody and placed at the Monterey County jail, the cells intended for inmates with mental illness still contained the hanging hazards.

## JURISDICTION AND VENUE



1 employees, agents and representatives, provides an important governmental function  
2 and stands in the place of the COUNTY OF MONTEREY in carrying out its duties at  
3 the Monterey County Jail. In its capacity as the provider of these important  
4 governmental services to the inmates of the Monterey County Jail, CFMG and its  
5 employees, agents and representatives were in a special relationship with said  
6 inmates.

7 15. At all relevant times mentioned herein, Defendant CFMG, and its  
8 employees, agents and representatives, were responsible for the provision of health  
9 services to decedent Erick de Anda during his detention in the Monterey County Jail.  
10 Defendant CFMG was in a special relationship with Erick de Anda.

11 16. At all relevant times mentioned herein, Defendant CFMG, and its  
12 employees, agents, officers, administrators and representatives, were acting under the  
13 color of law. Courts have treated medical groups employed to provide prison medical  
14 services as local government entities for purposes of deliberate indifference claims.  
15 *See Carrea v. California*, No. EDCV 07-1148-CAS (MAN), 2009 WL 1770130, at  
16 \*8 & n.5 (C.D. Cal. June 18, 2009) (collecting cases).

17 17. Defendant RAYMOND HERR, MD, is, and at all times relevant hereto,  
18 was Chief Medical Officer and President, California Forensic Medical Group. At all  
19 times relevant hereto, he was responsible for overseeing the delivery of medical,  
20 mental health and dental care at the Monterey County Jail facilities, including  
21 standards of medical care and utilization review. Defendant RAYMOND HERR is  
22 and was responsible for promulgation of policies and procedures and allowance of the  
23 practices/customs pursuant to which the acts of CFMG alleged herein were  
24 committed. Private physicians employed to provide medical care to inmates are state  
25 actors for purposes of § 1983. *See West v. Atkins*, 487 U.S. 42, 54-55 (1988). At all  
26 times relevant hereto the present defendant was acting under the color of law.

27 18. Defendant TAYLOR FITHIAN (hereinafter also “FITHIAN”), is, and  
28 was at all relevant times mentioned herein, the co-founder and President for  
Defendant CFMG. Defendant FITHIAN was previously the Medical Director and

1 Chief Psychiatrist for Mental Health Services for CFMG, and is now the Chief of  
2 Behavioral Health Services for CFMG. Defendant FITHIAN is also the psychiatrist at  
3 Monterey County Jail, providing psychiatric services at the Jail, and overseeing  
4 provision of mental health by other CFMG staff at the Jail. The present defendant is  
5 and was responsible for promulgation of policies and procedures and allowance of the  
6 practices/customs pursuant to which the acts of CFMG, and its employees and agents,  
7 alleged herein were committed. Private physicians employed to provide medical care  
8 to inmates are state actors for purposes of § 1983. *See West v. Atkins*, 487 U.S. 42,  
9 54-55 (1988). At all times relevant hereto, the present defendant was acting under the  
10 color of law.

11 19. Defendant KIP HALLMAN, hereafter also referred to as “defendant  
12 HALLMAN”, is, and at all times was, the Chief Executive Officer for CFMG and  
13 had the duty and responsibility for managing and overseeing all CFMG operations,  
14 including those at the Monterey County Jail. The present defendant is and was  
15 responsible for promulgation of policies and procedures and allowance of the  
16 practices/customs pursuant to which the acts of CFMG, and its employees and agents,  
17 alleged herein were committed. Private managers employed to provide medical care  
18 to inmates are state actors for purposes of § 1983. *See West v. Atkins*, 487 U.S. 42,  
19 54-55 (1988). At all times relevant hereto, the present defendant was acting under the  
20 color of law.

21 20. Defendant CINDY WATSON, hereafter also “Defendant WATSON”, is,  
22 and at all times was, the Chief Operating Officer for CFMG and had the duty and  
23 responsibility for overseeing all CFMG operations at the Monterey County Jail. The  
24 present defendant is and was responsible for promulgation of policies and procedures  
25 and allowance of the practices/customs pursuant to which the acts of CFMG, and its  
26 employees and agents, alleged herein were committed. Private managers employed to  
27 provide medical care to inmates are state actors for purposes of § 1983. *See West v.*  
28 *Atkins*, 487 U.S. 42, 54-55 (1988). At all times relevant hereto, the present defendant  
was acting under the color of law.

1        21. Defendant MARY ANN ROWE (hereinafter also “defendant ROWE”),  
2 is, and was at all relevant times mentioned herein, Defendant CFMG’s on-site mental  
3 health provider for Monterey County Jail. Defendant ROWE is responsible for the  
4 day-to-day provision and administration of mental health care at the Jail. Defendant  
5 ROWE is also responsible for policies, procedures, and practices regarding provision  
6 of mental health care at the Jail, and is responsible for training and supervision of  
7 CFMG medical staff servicing the Jail. In addition, on information and belief,  
8 defendant ROWE released decedent Erick de Anda from suicide watch on August 29,  
9 2015. Private physicians, such as the present defendant, employed to provide medical  
10 care to inmates are state actors for purposes of § 1983. *See West v. Atkins*, 487 U.S.  
11 42, 54-55 (1988). At all times relevant hereto, the present defendant was acting under  
12 the color of law.

13        22. Defendant ELIZABETH FALCON (hereafter “defendant FALCON”) is,  
14 and at all relevant times hereto was, the Director of Behavioral Health Services for  
15 CFMG, and her duties included the developing, implementing and monitoring of  
16 policies and procedures for the provision of mental health services at the Monterey  
17 County Jail. Private physicians, such as the present defendant, employed to provide  
18 medical care to inmates are state actors for purposes of § 1983. *See West v. Atkins*,  
19 487 U.S. 42, 54-55 (1988). At all times relevant hereto, the present defendant was  
20 acting under the color of law.

21        23. Defendant YVONNE MAXFIELD, RN (hereafter “Defendant  
22 MAXFIELD”) is, and, at all times relevant to, was the Director of Operations for  
23 CFMG at the Monterey County Jail. She was responsible for overseeing CFMG’s  
24 operations at the Monterey County Jail. She reviewed operations and program  
25 practices including staffing, hiring, training, retention and performance review. She,  
26 along with her other CFMG co-defendants, worked in conjunction with jail  
27 administration and the CFMG on-site health care staff to carry out the duties that  
28 CFMG was contracted to carry out and to ensure compliance with CFMG’s goals and  
objectives and the County’s operational plan, court orders and the settlement that

1 CFMG and the County were party to with respect to the operation of the Monterey  
2 County Jail. Medical services managers, such as the present defendant, employed to  
3 provide medical care to inmates are state actors for purposes of § 1983. See *West v.*  
4 *Atkins*, 487 U.S. 42, 54-55 (1988). At all times relevant hereto, the present defendant  
5 was acting under the color of law.

6 24. JODEL JENCKS (hereafter “Defendant JENCKS”) is, and, at all times  
7 relevant to, was a Director of Operations for CFMG. She was responsible for  
8 overseeing CFMG’s operations at the Monterey County Jail. She reviewed operations  
9 and program practices including staffing, hiring, training, retention and performance  
10 review. She, along with her other CFMG co-defendants, worked in conjunction with  
11 jail administration and the CFMG on-site health care staff to carry out the duties that  
12 CFMG was contracted to carry out and to ensure compliance with CFMG’s goals and  
13 objectives and the County’s operational plan, court orders and the settlement that  
14 CFMG and the County were party to with respect to the operation of the Monterey  
15 County Jail. Medical services managers, such as the present defendant, employed to  
16 provide medical care to inmates are state actors for purposes of § 1983. See *West v.*  
17 *Atkins*, 487 U.S. 42, 54-55 (1988). At all times relevant hereto, the present defendant  
18 was acting under the color of law.

19 25. Defendant DOES 1 through 5, are, and were, at all relevant times  
20 mentioned herein, Defendant CFMG’s employees, agents and representatives  
21 involved in the carrying out of services to inmates at the Monterey County Jail.  
22 Defendant DOES 1 through 6 are, and/or were, also responsible for policies,  
23 procedures, and practices regarding provision of health care at the Jail, and is  
24 responsible for training and supervision of CFMG medical staff servicing the Jail.  
25 Individuals employed to provide medical services to inmates are state actors for  
26 purposes of § 1983. See *West v. Atkins*, 487 U.S. 42, 54-55 (1988)

27 26. Defendant COUNTY OF MONTEREY (hereinafter also “COUNTY”) is  
28 and was, at all relevant times hereto, a public entity, duly organized and existing  
under and by virtue of the laws of the State of California, with the capacity to sue and

1 be sued. Defendant COUNTY is responsible for the actions, omissions, policies,  
2 procedures, practices and customs of its various agents and agencies.

3 27. Defendant COUNTY owns, operates, manages, directs and controls  
4 Defendant MONTEREY COUNTY SHERIFF'S OFFICE (hereinafter also  
5 "MCSO"), also a separate public entity, which employs other Doe Defendants in this  
6 action. At all times relevant to the facts alleged herein, Defendant COUNTY was  
7 responsible for assuring that the actions, omissions, policies, procedures, practices  
8 and customs of its employees, including MCSO employees, complied with the laws  
9 and the Constitutions of the United States and of the State of California. Defendant  
10 COUNTY, through MCSO, is and was responsible for ensuring the safety of all  
11 persons incarcerated in the Jail and providing them appropriate medical and mental  
12 health treatment.

13 28. Defendant STEVE BERNAL (hereinafter also "BERNAL" and  
14 "SHERIFF BERNAL") is and, since December 31, 2014, has been the Sheriff-  
15 Coroner of Defendant COUNTY OF MONTEREY, the highest position in MCSO.  
16 As Sheriff, Defendant BERNAL is and was responsible for the hiring, screening,  
17 training, retention, supervision, discipline, counseling, and control of all MCSO  
18 employees and/or agents. Defendant SHERIFF BERNAL is and was charged by law  
19 with oversight and administration of the Monterey County Jail (hereinafter also  
20 "Jail"), including ensuring the safety of the inmates housed therein. Defendant  
21 SHERIFF BERNAL also is and was responsible for the promulgation of the policies  
22 and procedures and allowance of the practices/customs pursuant to which the acts of  
23 the MCSO alleged herein were committed. Defendant SHERIFF BERNAL is being  
24 sued in his individual and official capacities.

25 29. Defendant JOHN MIHU (hereinafter also "MIHU") is and was at all  
26 times relevant herein a Commander in MCSO, one of the highest-level supervisory  
27 positions. In September 2015, Defendant MIHU was the Jails Operations  
28 Commander, and was primarily responsible for assisting the Sheriff-Coroner with  
oversight and administration of the Jail, including ensuring the safety of the inmates

1 housed therein. As Jails Operations Commander, Defendant MIHU was responsible  
2 for supervision of MCSO employees and/or agents at the Jail, and for the  
3 promulgation of the policies and procedures and allowance of the practices/customs  
4 pursuant to which the acts of the MCSO alleged herein were committed. Defendant  
5 MIHU also directly supervised Defendant DOES 6 through 10. Defendant MIHU is  
6 being sued in his individual and official capacities.

7 30. Defendant JAMES BASS (hereinafter also “BASS”) is and was at all  
8 times relevant herein a Commander in MCSO, one of the highest-level supervisory  
9 positions. In September of 2015, Defendant BASS’s responsibilities at the Jail  
10 included medical liaison, overseeing the classification unit, and compliance. As  
11 Commander, Defendant BASS was responsible for assisting the Sheriff-Coroner with  
12 oversight and administration of the Jail, including ensuring the safety of the inmates  
13 housed therein. In September of 2015, Defendant BASS was specifically responsible  
14 for working with CFMG, and working on issues related to the class action lawsuit  
15 against the Jail for, *inter alia*, failure to provide adequate medical and mental health  
16 treatment to inmates. Defendant BASS was and is responsible for supervision of  
17 MCSO employees and/or agents at the Jail, and for the promulgation of the policies  
18 and procedures and allowance of the practices/customs pursuant to which the acts of  
19 the MCSO alleged herein were committed. Defendant BASS also directly supervised  
20 Defendant DOES 6 through 10. Defendant BASS is being sued in his individual and  
21 official capacities.

22 31. Defendants DOES 6 through 10 are, and were at all relevant times  
23 mentioned herein, deputies, sergeants or civilian employees in MCSO. As Sergeants,  
24 Defendant DOES 6 through 10 are supervisors at the Monterey County Jail, are  
25 responsible for ensuring the safety of the inmates housed therein, and supervise all of  
26 the deputies that are on duty during their shifts. Defendant DOES 6 through 10 were,  
27 among other roles, shift supervisors on September 16, 2015, when Erick de Anda  
28 died. Defendants DOES 6 through 10 are being sued in their individual capacities.

1           32. Defendants DAVID COOPER (hereinafter also “COOPER”) and  
2 DAVID RAMON (hereinafter also “RAMON”) are, and were at all relevant times  
3 mentioned herein, a MCSO sergeant and deputy, respectively. Defendants COOPER  
4 and RAMON were assigned to work at Monterey County Jail, and were responsible  
5 for carrying out MCSO policies and procedures and for ensuring the safety of inmates  
6 at the Jail. Defendants COOPER and RAMON were assigned to work floor deputies  
7 for the isolation area of the men’s section of the Jail on the day of September 16,  
8 2015, when Erick de Anda died. Defendants COOPER and RAMON are being sued  
9 in their individual capacities.

10           33. At all relevant times, each of the Defendants engaged in the acts or  
11 omissions alleged herein under color of state law.

12           34. At all relevant times, each of the Defendants DOES 1 through 10 was  
13 acting within his or her capacity as an employee, agent, representative and/or servant  
14 of Defendants COUNTY OF MONTEREY and CFMG and is sued in their individual  
15 capacities.

16           35. At times in the present complaint, defendants SHERIFF STEVE  
17 BERNAL, COMMANDER JOHN MIHU, COMMANDER JAMES BASS,  
18 SERGEANT DAVID COOPER, DEPUTY DAVID RAMON, and DOES 6 through  
19 10 will be referred to collectively as “County defendants.”

20           36. At times in the present complaint, defendants RAYMOND HERR,  
21 TAYLOR FITHIAN, KIP HALLMAN, MARIANNE ROWE, ELIZABETH  
22 FALCON, CINDY WATSON, YVONNE MAXFIELD, JODEL JENCKS, and DOE  
23 1 through 5 will be referred to collectively as “CFMG defendants.”

24           37. The true names of Defendants DOES 1 through 10, inclusive, are  
25 unknown to Plaintiffs, who therefore sue these Defendants by such fictitious names.  
26 Plaintiffs will seek leave to amend this Complaint to show the true names and  
27 capacities of these Defendants when they have been ascertained. Each of the  
28 fictitiously named Defendants is responsible in some manner for the conduct and  
liabilities alleged herein.

1           38. Defendants DOES 6 through 10 are and were also supervisory  
2 employees for Defendant COUNTY OF MONTEREY who were acting under color  
3 of law within the course and scope of their duties as deputies for Defendant  
4 COUNTY OF MONTEREY. Defendants DOES 6 through 10 were acting with the  
5 complete authority and ratification of their principal, Defendant COUNTY OF  
6 MONTEREY.

7           39. Defendants DOES 6 through 10 were also duly appointed deputies,  
8 sergeants, lieutenants, detectives, or other supervisors, officials, executives and/or  
9 policymakers of MCSO, a department and subdivision of Defendant COUNTY OF  
10 MONTEREY, and at all times mentioned herein said Defendants were acting in the  
11 course and scope of their employment with Defendant COUNTY OF MONTEREY,  
12 which is liable under the doctrine of *respondeat superior* pursuant to California  
13 Government Code § 815.2.

14           40. Defendants DOES 6 through 10 are managerial, supervisory, and  
15 policymaking employees of Defendant COUNTY OF MONTEREY, who were acting  
16 under color of law within the course and scope of their duties as managerial,  
17 supervisory, and policymaking employees for Defendant COUNTY OF  
18 MONTEREY. Defendants DOES 6 through 10 were acting with the complete  
19 authority and ratification of their principal, Defendant COUNTY OF MONTEREY.

20           41. Each of the Defendants caused and is responsible for the unlawful  
21 conduct and resulting by, inter alia, personally participating in the conduct, or acting  
22 jointly and in concert with others who did so; by authorizing, acquiescing or failing to  
23 take action to prevent the unlawful conduct; by promulgating policies and procedures  
24 pursuant to which the unlawful conduct occurred; by failing and refusing, with  
25 deliberate indifference to Plaintiffs' rights, to initiate and maintain adequate  
26 supervision and/or training; and, by ratifying the unlawful conduct that occurred by  
27 agents and peace officers under their direction and control. Whenever and wherever  
28

reference is made in this Complaint to any act by a Defendant, such allegation and reference shall also be deemed to mean the acts and failures to act of each Defendant individually, jointly and severally. They are sued in their individual and official capacities and in some manner are responsible for the acts and omissions alleged herein. Plaintiffs will ask leave of this Court to amend this Complaint to allege such name and responsibility when that information is ascertained. Each of the Defendants is the agent of the other.

### **FACTS COMMON TO ALL CLAIMS FOR RELIEF**

#### **I. September 16, 2015 – Eric de Anda Commits Suicide in an Isolation Cell.**

42. Erick de Anda suffered from severe schizophrenia since childhood.

43. On August 25, 2015, at approximately 6:35 p.m., MCSO deputies arrested Erick de Anda for the death of his mother during a schizophrenic episode. At the time of his arrest, Erick de Anda was 24 years old and suffered from a lifetime of severe schizophrenia, including episodes of severe psychosis and suicidal ideations.

44. On August 25, 2015, at approximately 6:55 p.m., decedent Erick de Anda was transported to the Monterey County Jail.

45. On August 26, 2015, at approximately 3:53 a.m., Erick de Anda was moved from booking to a single cell.

46. On August 27, 2015, at approximately 7:55 p.m., Erick de Anda was moved to a “safety cell.” Safety cells at the Monterey County Jail are small cells with padded rubber walls. Safety cells do not contain furniture, mattress, or blanket, and a grate in the floor is used in lieu of a toilet.

47. On August 28, 2015, at approximately 8:40 a.m., Defendant ROWE, under the supervision of defendant FITHIAN and other defendants, medically “cleared” decedent Erick de Anda.

48. On August 29, 2015, Defendant ROWE gave orders to discontinue suicide watch and to transfer decedent Erick de Anda from a safety cell to an isolation cell. Specifically, decedent Erick de Anda was placed in Isolation Cell

1 Number 2. The CFMG defendants knew that there were hanging points, i.e.,  
2 appurtenances within the cell such as smoke detectors, pipes, bars and other fixtures  
3 from which an inmate could hang himself.

4 49. The isolation cell logs associated with decedent Erick de Anda indicated  
5 that he was a “hi-risk suicide.” Despite this, he was moved to an isolation cell where  
6 he was no longer monitored directly.

7 50. By this time the County defendants and the CFMG defendants knew that  
8 Erick de Anda suffered from serious mental illness. They had learned of, and  
9 confirmed, his condition through media reports related to the killing of his mother,  
10 through interviews with him, through conversations during court proceedings and  
11 with his attorneys. Each of the defendants knew that Erick de Anda had a father and  
12 that his father was visiting him regularly and/or was attending the proceedings related  
13 to Erick de Anda’s criminal case.

14 51. On September 16, 2015, Defendants COOPER and RAMON, were  
15 working as floor deputies in the isolation area of the Monterey County Jail.

16 52. On September 16, 2015, at approximately 3:50 p.m., Defendant  
17 COOPER and RAMON found Erick de Anda’s body suspended from a bed sheet that  
18 was tied to the cover of a smoke detector.

19 53. Eventually, Erick de Anda’s suspended body was taken down from the  
20 hanging bedsheet. Erick de Anda was pronounced dead at Natividad Medical Center  
21 on September 16, 2015 at 3:55 p.m.

22 **II. Defendants’ Knowledge of Inadequacy of Suicide Prevention Procedures**  
23 **and Hazards Existing in Isolation Cells of the Monterey County Jail.**

24 54. By the time that Erick de Anda was moved to the isolation cell, the  
25 County defendants and the CFMG defendants, and each of them, understood the  
26 isolation cell where decedent Erick de Anda was housed on August 29, 2015 and  
27 until his death on September 16, 2015 contained suicide hazards and was  
28 unreasonably dangerous for housing inmates with identified mental health concerns.

55.

1           56. Pursuant to its contract and related agreements with MONTEREY  
2 COUNTY, CFMG took over and was solely responsible for the provision of medical  
3 and mental health services at the Monterey County jail. Essentially, MONTEREY  
4 COUNTY turned over this important function to CFMG. Through their various  
5 agreements that were in place by the time Erick de Anda was taken into custody at  
6 the Monterey County jail, the CFMG defendants were to provide the following to  
7 MONTEREY COUNTY at the Monterey County jail:

- 8           a. Staffing for the jail's medical and mental health units;
- 9           b. Administrative structure, medical direction and operational oversight for  
10           the medical and mental health units;
- 11           c. Oversight of the day-to-day operations of the health services programs at  
12           the jail;
- 13           d. Design and implementation of a suicide prevention program, including  
14           the related policies and procedures to fully and safely carry out such  
15           program;
- 16           e. Development, implementation and revision policies and procedures  
17           which relate to the overall provision of mental health and medical  
18           services, including the operational aspects of such services and  
19           compliance with regulations and statutes;
- 20           f. Development, implementation and revision policies, procedures and  
21           practices for the training of custodial staff at the jail;
- 22           g. Monitoring, with the administrative jail staff, of the operation of the  
23           medical units, including the operation of the isolation units for mentally  
24           ill inmates;
- 25           h. Identifying of all unsafe or unhealthy conditions within the jail facilities  
26           related to the provision of medical and mental health services, and  
27           proposing of corrective measures of such conditions in a timely manner;
- 28

- 1 i. Provide continuous training to detention staff regarding the screening of  
2 inmates, identification of mentally ill inmates, risk recognition, and  
3 suicide prevention.

4 57. County Defendants and CFMG Defendants had been on notice for years  
5 that their provision of medical and mental health treatment to inmates at the  
6 Monterey County Jail was inadequate and resulted in needless harm and death.

7 58. Decedent Erick de Anda was housed in Isolation Cell Number 2 of either  
8 the A-pod or B-pod units which consist of single cells that predominantly, in  
9 accordance with Defendant COUNTY and Defendant CFMG's policies, procedures,  
10 and practices, are used to house individuals with mental health needs. Other units,  
11 including C-pod, are used as overflow housing for individuals with mental health  
12 needs. In accordance with Defendant COUNTY and Defendant CFMG's policies,  
13 procedures, and practices, A-pod, B-pod, and C-pod are "lockdown" units, meaning  
14 that individuals housed there generally are locked in their cells for approximately  
15 twenty-three hours a day and permitted to use the dayroom, take a shower, or do  
16 other activities outside the cell for approximately one hour a day. In accordance with  
17 Defendant COUNTY and Defendant CFMG's policies, procedures, and practices,  
18 individuals housed in lockdown units are permitted to come out for visits, court or  
19 medical appointments, and certain jail events. In accordance with Defendant  
20 COUNTY and Defendant CFMG's policies, procedures, and practices, individuals  
21 with mental health needs are housed in A-pod and B-pod because they are single  
22 cells, and thus the risks of assaults between inmates is lessened. In accordance with  
23 Defendant COUNTY and Defendant CFMG's policies, procedures, and practices, an  
24 MCSO deputy does hourly welfare and safety checks of the pod cells. Those hourly  
25 checks consist of walking through both tiers of each pod and can be completed within  
26 one or two minutes. In accordance with Defendant COUNTY and Defendant  
27 CFMG's policies, procedures, and practices, no additional safety checks are  
28 performed when an individual is placed in a lockdown cell upon release from suicide  
watch.

59. The lockdown cells, including Isolation Cell Number 2 where decedent Erick de Anda was housed from August 29, 2015 to the time of his death on September 16, 2015, contain beds with sheets. Including records of Defendant COUNTY OF MONTEREY and the sworn testimony of Defendant BASS, at all relevant times hereto, the lockdown cells had attachment points that could be used for suicide by hanging, including air vents and smoke detectors located on the walls and ceilings.

60. As established in *Estate of Joshua Claypole, et al., v. County of Monterey, et al.*, (USDC Case No. 5:14-cv-02730-BLF), the lockdown cells, including the one that Erick de Anda died in, contained various different obvious choking points and suicide hazards; that is, appurtenances from which inmates could hang themselves. These included smoke detectors, pipes, bars and other fixtures within the cell.

61. Prior to the death of Erick de Anda, other persons in the custody of the County defendants and supervised and cared for by the CFMG defendants had committed suicide by similar, if not identical, means during their incarcerations at Monterey County Jail:

- a. In 2010 and 2011, there were at least two suicides by hanging in lockdown cells.
- b. In 2011 and 2012, at least five other individuals attempted to hang themselves with bedsheets, at least three of which were attached to vents or grates in their cells.
- c. As established in *Estate of Joshua Claypole, et al., v. County of Monterey, et al.*, case number 5:14-cv-02730-BLF (N.D. Cal.), Docket Number 55, in 2013, decedent Joshua Claypole hung himself using a bed sheet during the time that he was housed in an isolation cell at Monterey County Jail.
- d. As established in *Estate of Sandra Vela, et al., v. County of Monterey, et al.*, case number 5:16-cv-02375-BLF (N.D. Cal.), specifically Docket

1 Number 54, decedent Sandra Vela hung herself using a bed sheet during  
2 the time that she was housed in an isolation cell at Monterey County Jail.

3 62. A December 30, 2011 Jail Needs Assessment commissioned by  
4 Defendant COUNTY OF MONTEREY found a number of problems with respect to  
5 protecting inmates from harm at the Jail, including:

- 6 a. “suicide hazard elimination is not as stringent as it should be to prevent  
7 self-harm and the attendant liability;”  
8 b. “glaring example of the physical plan limitations in the existing jail is  
9 the design of the control or ‘guard’ station, and the ability of staff to  
10 directly supervise inmates. At best there is intermittent observation of  
11 the inmates;” and  
12 c. the operation of the Jail as an “indirect supervision jail” makes mental  
13 health issues “considerably more difficult to recognize, manage, and  
14 treat.”

15 63. The 2011 Jail Needs Assessment also found that Defendants’ policies  
16 and procedures for screening, supervising, and treating inmates at risk for suicide  
17 were inadequate, and that chronic understaffing of the jail hindered the ability of  
18 Defendants to provide adequate medical care and maintain inmate safety and security.

19 64. On May 23, 2013, the federal class action *Jesse Hernandez, et al., v.*  
20 *County of Monterey, et al.*, case number 5:13-cv-2354-PSG (N.D. Cal.), was filed  
21 against Defendants COUNTY OF MONTEREY and CFMG alleging that these  
22 Defendants were deliberately indifferent to the medical and mental health needs of  
23 inmates housed at the Monterey County Jail, resulting in grievous and unnecessary  
24 suffering, harm, and death.

25 65. In 2013, experts were jointly retained by Defendants COUNTY OF  
26 MONTEREY, CFMG and the Plaintiffs in the class action lawsuit to evaluate the  
27 Monterey County Jail. These experts identified a variety of deficiencies in the  
28 provision of medical and mental health care at the Jail and the presence of hazards  
including the conditions in the lockdown units that put inmates at unacceptable risk

1 of suicide and self-harm. Each of the CFMG defendants participated in the hiring of  
2 said experts and, by the end of 2013, each of the CFMG were presented with the  
3 findings of such experts. Through these findings, each of the CFMG defendants  
4 again were informed of the dangerousness of the isolation cells and the great danger  
5 that existed there to inmates who suffered from mental illness.

6 66. Despite these known suicide hazards and deficiencies in monitoring  
7 inmates in the lockdown units, at the time decedent Erick de Anda was in the  
8 Monterey County Jail, Defendant COUNTY OF MONTEREY had a policy,  
9 procedure, practice and/or custom of housing inmates with identified mental health  
10 concerns specifically in isolation in these lockdown units. The CFMG defendants  
11 were also aware of these policies, procedures, practices and customs and each of  
12 them followed it and, through that, ratified it.

13 67. In 2013, the matter of *Jesse Hernandez, et al., v. County of Monterey, et*  
14 *al.*, case number 5:13-cv-2354-PSG (N.D. Cal.) was filed and served upon the present  
15 defendants. This again put them on notice of the great risk of suicide that existed  
16 within the Monterey County jail, including in the cell that Erick de Anda died in.

17 68. Though an agreement with the plaintiffs in the *Hernandez* matter, the  
18 present defendants hired experts which examined the dangers that were present in the  
19 Monterey County jail and through these experts learned again of the great risk of  
20 death to mentally ill inmates in the isolation cells within the jail.

21 69. On April 14, 2015, a federal court issued an order granting a motion for  
22 a preliminary injunction in the class action lawsuit that had been filed in 2013 against  
23 Defendants COUNTY OF MONTEREY and CFMG and other of the defendants  
24 named herein, *Jesse Hernandez, et al., v. County of Monterey, et al.*, case number  
25 5:13-cv-2354-PSG (N.D. Cal.).

26 70. In that order, Defendants COUNTY OF MONTEREY, the County  
27 defendants, CFMG and the CFMG defendants were ordered to “remove all hanging  
28 points and other hazards in the jail’s administrative segregation units that pose a risk  
of being used by inmates to harm themselves or attempt suicide.” The court’s order,

1 a copy of which is attached hereto, put the present defendants on notice of the  
 2 immediate danger that existed within the jail to inmates with mental illness. *See,*  
 3 *Exhibit 1, Order Granting Motion for Preliminary Injunction* (hereafter “Order”).

4 71. In the Order, found constitutional and statutory violations, and the court  
 5 noted as follows:

- 6 a. “The experts identified a variety of deficiencies and hazards, including:  
 7 ...administrative segregation unit conditions that put inmates at  
 8 unacceptable risk of suicide and self-harm;” *Order at 2:3.*
- 9 b. “Plaintiffs provide significant evidence that Defendants’ policies and  
 10 practices constitute deliberate indifference to Plaintiffs’ serious medical  
 11 needs, particularly for the mentally ill.” *Order at 21:5*
- 12 c. “As a matter of policy and practice, Defendants house the inmates with  
 13 the most serious mental illness and who are most clinically unstable in  
 14 segregation units *because* of their mental illness.” *Order at 21:10.*
- 15 d. “Despite four suicides in administrative segregation, Defendants  
 16 continue to place clinically unstable mentally ill patients in segregation  
 17 and fail to eliminate potential suicide hazards. And Defendants fail to  
 18 engage in practices – conducting pre-segregation screening, providing  
 19 adequate structured and unstructured out-of-cell time, utilizing a suicide  
 20 risk assessment tool – known to reduce the risks created by  
 21 administrative segregation.” *Order at 21:10-22:3.*
- 22 e. “Each [of the four suicides that had occurred since 2010] occurred in  
 23 administrative segregation cells.... Each inmate committed suicide by  
 24 attaching sheets or other fabric in their cell to easily accessible hanging  
 25 points. By the time that custody staff conducting health and welfare  
 26 checks discovered that the inmates were attempting suicide by hanging,  
 27 two of the inmates had already died and two others inflicted injuries so  
 28 severe that they never regained consciousness.” *Order at 22:14-23:1.*

72. Specifically, with regard to Defendant COUNTY OF MONTEREY's policies and procedures for inmates in administrative segregation (i.e., lockdown) housing, the court found that Defendant COUNTY OF MONTEREY's policy regarding health and safety checks in administrative segregation units did not meet correctional standards to prevent suicides and placed all inmates, especially those with serious mental illness, at risk of serious harm.

73. CFMG and the COUNTY were ordered to, among other things, prepare a plan to remedy the constitutional and statutory violations, including the removal of all hanging points and other hazards in the jail's administrative segregation units that pose a risk of being used by inmates to harm themselves or attempt suicide. By the time that Erick de Anda, CFMG, the CFMG defendants, the COUNTY and the County defendants failed to carry out this element of the plan as well as those elements of the plan which related to the monitoring of inmates suffering from mental illness such as Erick de Anda.

74. The *Hernandez* Court's April 2015 findings regarding the failures of County Defendants to take actions to eliminate the known suicide hazards in their lockdown units directly reflected the repeated decision by the County defendants and the CFMG defendants not to take these actions or direct that they be taken. The *Hernandez* Court's findings that the County defendants and the CFMG defendants failed to implement practices to reduce the risk to inmates in administrative segregation also directly reflected the repeated decision by said defendants not to implement such practices. This directly resulted in harm to decedent Erick de Anda.

**II. Defendants' knowledge that custody officers regularly failed to conduct required hourly safety checks and failure to take adequate measures to address and ameliorate this failure.**

75. Welfare and safety checks by custody staff, when done correctly, are an important part of protecting inmates in the Monterey County Jail from harm, including preventing suicide. Both the County defendants and the CFMG defendants knew that health and welfare checks conducted in lockdown units were part of

1 suicide prevention programs and that such checks were necessary for suicide  
2 prevention.

3 76. Prior to the death of decedent Erick de Anda, the County defendants and  
4 the CFMG defendants were aware that there was a problem with custody officers  
5 failing to actually perform required welfare and safety checks in the housing units at  
6 the Jail.

7 77. The County defendants and the CFMG defendants became aware of  
8 systemic problems with welfare and safety checks as early as 2011, including regular  
9 failure by deputies to conduct checks and inaccurate logging of checks.

10 78. Despite said defendants' knowledge that deputies were failing to conduct  
11 welfare and safety checks in accordance with the COUNTY OF MONTEREY's  
12 policies, and that deputies were falsifying safety check logs, said defendants did not  
13 take adequate measures to correct these failures, in effect ratifying the behavior of the  
14 deputies and the supervisors of the Monterey County Jail and the CFMG jail staff  
15 who turned a blind eye to this practice.

16 79. In 2014, Defendant COUNTY OF MONTEREY specifically assigned a  
17 sergeant at the Monterey County Jail to do a daily review of checks every day,  
18 purportedly to ensure that custody officers would perform them. However, during this  
19 monitoring, the sergeant reported ongoing, frequent, and repeated problems with  
20 custody officers actually performing these checks. The sergeant notified MCSO  
21 supervisors of these ongoing problems, including Defendants MIHU and BASS.  
22 However, Defendants MIHU and BASS failed to take any measures to correct these  
23 failures. The County defendants and the CFMG defendants knew of these persistent  
24 problems with welfare and safety checks, but failed to take any corrective action, kept  
25 Defendants MIHU and BASS in place as supervisors of the Jail without any further  
26 training or corrective action, thus permitting and condoning the ongoing failure to  
27 conduct adequate welfare checks.

28 80. The County defendants and the CFMG defendants knew of persistent  
and ongoing problems with welfare and safety checks, and understood these to be an

1 important component of the Monterey County Jail's suicide prevention plan, but they  
2 did not direct that any command staff or officers be disciplined for failing to conduct  
3 safety checks in accordance with policy or for falsifying safety check logs. Said  
4 defendants helped establish a practice at the Monterey County Jail of failing to  
5 conduct welfare and safety checks.

6 81. 2015 Grand Jury Report on the Monterey County Jail found that welfare  
7 and safety checks were still not being conducted correctly. The Report concluded,  
8 "Another problem the MCCGJ discovered was that some logs are incorrectly or  
9 falsely filled out, with checks being claimed when they were not actually done." The  
10 Report stated that audits of the Jail in 2015 reviewed by the Grand Jury showed that  
11 safety checks were "frequently missed or skipped, or not adequately documented."  
12 As an example, the Report noted that in January 2015, full compliance with the  
13 required checks "was achieved on only eight days."

14 82. Despite all of this information and evidence that welfare and safety  
15 checks were not being done as required, and that failure to conduct these checks  
16 created substantial risk of harm to inmates, the County defendants and the CFMG  
17 defendants failed to take adequate steps to address and correct the problem.

18 83. The County defendants and the CFMG defendants failed to provide  
19 decedent Erick de Anda necessary medical and mental health care, increasing his  
20 mental health symptoms; specifically housed him in isolation in a cell with known  
21 suicide hazards despite obvious symptoms of suicidality; and failed to ensure that  
22 basic procedures required of correctional facilities to protect inmates from harm were  
23 followed.

24 84. These actions and omissions by Defendants directly placed decedent  
25 Erick de Anda at substantial risk of the grievous and tragic harm that ultimately  
26 occurred.  
27  
28

**CLAIMS FOR RELIEF**

**FIRST CLAIM FOR RELIEF**

**Deliberate Indifference to Serious Medical and Mental Health Needs,  
Violation of the Fourteenth Amendment to the United States Constitution  
(Survival Action – 42 U.S.C. § 1983)**

**By Estate of Erick de Anda, As Against County Defendants, CFMG, CFMG  
Defendants and DOES 1 through 10**

85. Plaintiff Estate of Erick de Anda, by and through successor in interest Enrique de Anda, realleges and incorporates the foregoing paragraphs as if set forth herein.

86. County and CFMG Defendants had inadequate policies, procedures, and practices to ensure provision of minimally adequate medical and mental health treatment to inmates housed at the Jail.

87. County Defendants also failed to adequately supervise the provision of medical and mental health services at the Jail, violating their constitutional obligation to ensure that inmates entrusted to their care receive necessary treatment.

88. County Defendants also failed to properly train and supervise custody staff regarding policies, procedures, and practices that are necessary for the provision of adequate medical and mental health care, including conducting welfare and safety checks and responding to medical emergencies.

89. CFMG Defendants failed to promulgate and implement policies, procedures, and practices to ensure that medical staff, including mental health staff, met the standard of care when providing treatment to inmates.

90. County and CFMG Defendants were on notice for years prior to the death of Erick de Anda that their provision of medical and mental health care was woefully inadequate and fell far short of the minimum elements of a constitutional health care system. County and CFMG Defendants were on notice that their policies, procedures, and practices resulted in failure to provide necessary medical and mental

1 health care to the inmates at the Jail, and that this failure may result in otherwise  
2 preventable death.

3 91. County and CFMG Defendants' failure to correct their policies,  
4 procedures, and practices despite notice of significant and dangerous problems  
5 evidences deliberate indifference to the inmates in their care.

6 92. Decedent Erick de Anda's mental health needs were known to County  
7 and CFMG Defendants throughout the brief period of his incarceration at the  
8 Monterey County Jail. Despite this knowledge, and decedent Erick de Anda's  
9 obvious signs of serious psychological illness and emotional distress, Defendants  
10 failed to provide necessary mental health evaluation and treatment to Erick de Anda  
11 while he was held at the Jail.

12 93. The County defendants and the CFMG defendants placed Erick de Anda,  
13 or allowed Erick de Anda to be placed in a cell that they knew had hanging points.  
14 Said defendants knew that there was a substantial risk that Erick de Anda would hang  
15 himself, they knew that if he was allowed to be unsupervised in that cell with material  
16 such as a sheet that could be used as a ligature, that Erick de Anda would hang  
17 himself.

18 94. Defendant ROWE discharged decedent Erick de Anda from suicide  
19 watch without performing an assessment of his suicide risk that met the standard of  
20 care.

21 95. County and CFMG Defendants' actions and/or omissions as alleged  
22 herein, including but not limited to their failure to provide Erick de Anda with  
23 appropriate psychiatric care and to identify suicide risk, along with the acts and/or  
24 omissions of Defendants in failing to train, supervise, and/or promulgate appropriate  
25 policies and procedures to identify suicide risk and provide psychiatric treatment,  
26 constituted deliberate indifference to Erick de Anda's serious medical needs, health,  
27 and safety.

28 96. As a direct and proximate result of Defendants' conduct, the civil right  
of Erick de Anda, as protected by the Fourteenth Amendment of the U.S. Constitution

were violated. Further, decedent Erick de Anda experienced physical pain, severe emotional distress, and mental anguish, as well as loss of his life and other damages alleged herein.

97. The aforementioned acts of RAYMOND HERR, TAYLOR FITHIAN, KIP HALLMAN, MARIANNE ROWE, ELIZABETH FALCON, CINDY WATSON, YVONNE MAXFIELD, JODEL JENCKS, CALIFORNIA FORENSIC MEDICAL GROUP, INC., STEVE BERNAL, JOHN MIHU, JAMES BASS, DAVID COOPER, and DAVID RAMON were conducted with conscious disregard for the health, safety and welfare of Erick de Anda, and were therefore malicious, wanton, and oppressive. As a result, said defendants' actions justify an award of exemplary and punitive damages to punish the wrongful conduct alleged herein and to deter such conduct in the future.

## **SECOND CLAIM FOR RELIEF**

### **Failure to Protect from Harm,**

### **Violation of the Fourteenth Amendment to the United States Constitution**

### **(Survival Action – 42 U.S.C. § 1983)**

### **By Plaintiff Estate of Erick de Anda, As Against County Defendants, CFMG, CFMG Defendants and DOES 1 through 10**

98. Plaintiff Estate of Erick de Anda, by and through successor in interest Enrique de Anda, realleges and incorporates the foregoing paragraphs as if set forth herein.

99. County defendants, CFMG and CFMG Defendants were on notice that their deficient policies, procedures, and practices alleged herein created substantial risk of serious harm, including self-inflicted harm, to an inmate in decedent Erick de Anda's position.

100. Each Defendant could have taken action to prevent unnecessary harm to decedent Erick de Anda but refused or failed to do so.

101. By policy, procedure, and practice, County and CFMG Defendants specifically housed decedent Erick de Anda in isolation in a cell in the lockdown unit

1 at the Monterey County Jail that contained known suicide hazards. Defendants failed  
2 to take any reasonable steps to mitigate the obvious and well-known risk of harm,  
3 including self-inflicted harm, that was attendant to housing decedent Erick de Anda  
4 in this setting.

5 102. County Defendants including SHERIFF BERNAL, MIHU, BASS and  
6 DOES 6 through 10 also knew that deputies routinely failed to conduct required  
7 welfare and safety checks in the lockdown units and failed to take sufficient actions  
8 to correct this problem and ensure that necessary checks were performed.

9 103. Defendant BERNAL failed to take corrective action, discipline, or  
10 remove the command staff at the Monterey County Jail who directed the deputies to  
11 falsify safety check logs and violate the County's safety check policies. Defendant  
12 BERNAL ratified their actions, and the practices used under his watch.

13 104. County and CFMG Defendants were on notice that their policies,  
14 procedures, and practices for monitoring inmates in the lockdown units at the  
15 Monterey County Jail were inadequate and gave rise to a substantial risk of serious  
16 harm.

17 105. County and CFMG Defendants failed to properly train and supervise  
18 County staff and CFMG staff regarding policies, procedures, and practices necessary  
19 for the protection of inmates from harm, including self-inflicted harm.

20 106. County and CFMG Defendants' failure to correct their policies,  
21 procedures, and practices despite notice of significant and dangerous problems  
22 evidences deliberate indifference to the inmates in their care.

23 107. Defendant ROWE's discharge of decedent Erick de Anda from suicide  
24 watch in a safety cell directly back to a cell in the lockdown unit with known suicide  
25 hazards, without adequate suicide prevention precautions, directly placed decedent  
26 Erick de Anda at a substantial risk of serious harm, including suicide.

27 108. Defendants COOPER and RAMON's failure to conduct the required  
28 safety check of decedent Erick de Anda's housing unit on the date of his death  
evidences deliberate indifference to the risk of harm to decedent Erick de Anda.

109. Defendants SHERIFF BERNAL, MIHU, BASS and DOES 6 through 10 ratified Defendants COOPER and RAMON'S failure to conduct safety checks and falsification of logs.

110. As a direct and proximate result of Defendants' conduct, decedent Erick de Anda experienced physical pain, severe emotional distress, and mental anguish, as well as loss of his life and other damages alleged herein.

The aforementioned acts of RAYMOND HERR, TAYLOR FITHIAN, KIP HALLMAN, MARIANNE ROWE, ELIZABETH FALCON, CINDY WATSON, YVONNE MAXFIELD, JODEL JENCKS, CALIFORNIA FORENSIC MEDICAL GROUP, INC., STEVE BERNAL, JOHN MIHU, JAMES BASS, DAVID COOPER, and DAVID RAMON were conducted with conscious disregard for the health, safety and welfare of Erick de Anda, and were therefore malicious, wanton, and oppressive. As a result, said defendants' actions justify an award of exemplary and punitive damages to punish the wrongful conduct alleged herein and to deter such conduct in the future.

### **THRID CLAIM FOR RELIEF**

#### **Municipal Liability (*Monell* Liability) for Unconstitutional Policies, Procedures, Practices and Customs.**

**(42.S.C. § 1983)**

**By Plaintiff Estate of Erick de Anda, As to Defendants**

**Monterey County, Monterey County Sheriff's Office and CFMG.**

111. Plaintiff Estate of Erick de Anda, by and through successor in interest Enrique de Anda, realleges and incorporates the foregoing paragraphs as if set forth herein.

112. On and before September 6, 2015, and prior to the death of Erick de Anda, defendants Monterey County, Monterey County Sheriff's Office and CFMG were aware that the County defendants and the CFMG defendants had engaged in a custom and practice of callous and reckless disregard for the health and safety of

1 mentally ill inmates in the Monterey County jail as summarized in the paragraphs  
2 above.

3 113. Defendants Monterey County, Monterey County Sheriff's Office and  
4 CFMG, acting with deliberate indifference to the rights and liberties of those persons  
5 who would become inmates in the Monterey County jail, and of Erick de Anda, and  
6 of persons in Erick de Anda's class, situation and comparable position in particular,  
7 knowingly maintained, ratified, enforced and applied the policies, porcedures,  
8 customs and practices described herein above.

9 114. By reason of the aforementioned customs and practices, Plaintiffs were  
10 severely injured and subjected to pain and suffering as alleged above in the First and  
11 Second Claim for Relief.

12 115. Defendants Monterey County, Monterey County Sheriff's Office and  
13 CFMG, with various other officials, whether named or unnamed, had either actual or  
14 constructive knowledge of the deficient policies, practices and customs alleged in the  
15 paragraphs above. Despite having knowledge as stated above these Defendants  
16 condoned, tolerated and through actions and inactions thereby ratified such customs  
17 and practices. Said Defendants also acted with deliberate indifference to the  
18 foreseeable effects and consequences of these policies with respect to the  
19 constitutional rights of Erick de Anda and other individuals similarly situated.

20 116. The policies, practices, and customs implemented, ratified and condoned  
21 were affirmatively linked to and were a significantly influential force behind the  
22 injuries to Erick de Anda.

23 117. By reason of the aforementioned unconstitutional policies, procedures,  
24 customs and practices, Erick de Anda lost his life.

25 118. The conduct of CFMG in implementing, ratifying and condoning said  
26 policies, procedures, practices, and customs was malicious and done with done with a  
27 deliberate disregard for the health, safety and welfare of Erick de Anda. Further, the  
28

1 conduct of CFMG in implementing, ratifying and condoning said policies,  
 2 procedures, practices, and customs was done for monetary gain. As such, punitive  
 3 and exemplary damages should be awarded against CFMG in an amount sufficient to  
 4 meaningfully punish and deter it from such conduct in the future.

#### 5 **FOURTH CLAIM FOR RELIEF**

#### 6 **Deprivation of Substantive Due Process Rights,**

#### 7 **Loss of Parent/Child Relationship,**

#### 8 **Violation of First and Fourteenth Amendments to the United States Constitution**

9 **(42 U.S.C. § 1983)**

10 **(Against ALL Defendants)**

11 119. Plaintiff Enrique de Anda realleges and incorporates the foregoing  
 12 paragraphs as if set forth herein.

13 120. The aforementioned acts and/or omissions of Defendants in being  
 14 deliberately indifferent to decedent Erick de Anda's serious medical needs, health,  
 15 and safety, violating decedent Erick de Anda's constitutional rights, and their failure  
 16 to train, supervise, and/or take other appropriate measures to prevent the acts and/or  
 17 omissions that caused the untimely and wrongful death of Erick de Anda deprived  
 18 Plaintiff Enrique de Anda Garcia of his liberty interests in the parent-child  
 19 relationship in violation of their substantive due process rights as defined by the First  
 20 and Fourteenth Amendments of the Constitution.

21 121. As a direct and proximate result of the aforementioned acts and/or  
 22 omissions of Defendants, Plaintiffs suffered injuries and damages as alleged herein.

23 122. The aforementioned acts of individual Defendants and CFMG were  
 24 conducted with conscious disregard for the safety of Plaintiff and others, and were  
 25 therefore malicious, wanton, and oppressive. As a result, Defendants' actions justify  
 26 an award of exemplary and punitive damages to punish the wrongful conduct alleged  
 27 herein and to deter such conduct in the future.

28 123. The aforementioned acts of RAYMOND HERR, TAYLOR FITHIAN,  
 KIP HALLMAN, MARIANNE ROWE, ELIZABETH FALCON, CINDY

1 WATSON, YVONNE MAXFIELD, JODEL JENCKS, CALIFORNIA FORENSIC  
2 MEDICAL GROUP, INC., STEVE BERNAL, JOHN MIHU, JAMES BASS,  
3 DAVID COOPER, and DAVID RAMON were conducted with conscious disregard  
4 for the health, safety and welfare of Erick de Anda, and were therefore malicious,  
5 wanton, and oppressive. As a result, said defendants' actions justify an award of  
6 exemplary and punitive damages to punish the wrongful conduct alleged herein and  
7 to deter such conduct in the future.

8 **FIFTH CLAIM FOR RELIEF**

9 **Negligent Supervision, Training, Hiring, and Retention**

10 **(Survival Action – California State Law)**

11 **Against Defendants COUNTY OF MONTEREY, MONTEREY COUNTY**  
12 **SHERIFF'S OFFIC, STEVE BERNAL, JOHN MIHU, JAMES BASS, and**  
13 **DOES 6 through 10.**

14 124. Plaintiffs reallege and incorporate the foregoing paragraphs as if set  
15 forth herein.

16 125. Defendants had a duty to hire, supervise, train, and retain employees  
17 and/or agents so that employees and/or agents refrained from the conduct and/or  
18 omissions alleged herein.

19 126. Defendants breached this duty, causing the conduct alleged herein. Such  
20 breach constituted negligent hiring, supervision, training, and retention under the  
21 laws of the State of California.

22 127. As a direct and proximate result of Defendants' failure, Plaintiffs  
23 suffered injuries and damages as alleged herein.  
24  
25  
26  
27  
28

**SIXTH CLAIM FOR RELIEF**

**Negligent Supervision, Training, Hiring, and Retention**

**(Survival Action – California State Law)**

**Against Defendants CFMG, CFMG defendants, and DOES 1 through 5.**

128. Plaintiffs reallege and incorporate the foregoing paragraphs as if set forth herein as well as the contents of exhibit 1 hereto.

129. Defendants had a duty to hire, supervise, train, and retain employees and/or agents so that employees and/or agents refrained from the conduct and/or omissions alleged herein.

130. Defendants breached this duty, causing the conduct alleged herein. Such breach constituted negligent hiring, supervision, training, and retention under the laws of the State of California.

131. As a direct and proximate result of Defendants' failure, Plaintiffs suffered injuries and damages as alleged herein.

**SEVENTH CLAIM FOR RELIEF**

**Wrongful Death**

**(California Code Civ. Proc. § 377.60)**

**As Against All Defendants and DOES 1 through 10**

132. Plaintiffs reallege and incorporate the foregoing paragraphs as if set forth herein.

133. Erick de Anda's death was a direct and proximate result of the aforementioned intentional, wrongful and/or negligent acts and/or omissions of Defendants. Defendants' acts and/or omissions thus were also a direct and proximate cause of Plaintiffs' injuries and damages, as alleged herein.

134. As a direct and proximate result of Defendants' wrongful and/or negligent acts and/or omissions, Plaintiffs incurred expenses for funeral and burial expenses in an amount to be proved.

135. As a direct and proximate result of Defendants' wrongful and/or negligent acts and/or omissions, Plaintiffs suffered the loss of the services, society, care, and protection of the decedent, as well as the loss of the present value of his future services to his father. Plaintiffs are further entitled to recover prejudgment interest.

136. Plaintiff ESTATE OF ERICK DE ANDA is entitled to recover punitive damages against individual Defendants who, with conscious disregard of decedent Erick de Anda's rights, failed to provide him with health care services meeting the professional standard of practice, and/or failed to adhere to legal and professional standards of correctional supervision and administration.

137. The aforementioned acts of RAYMOND HERR, TAYLOR FITHIAN, KIP HALLMAN, MARIANNE ROWE, ELIZABETH FALCON, CINDY WATSON, YVONNE MAXFIELD, JODEL JENCKS, CALIFORNIA FORENSIC MEDICAL GROUP, INC., STEVE BERNAL, JOHN MIHU, JAMES BASS, DAVID COOPER, and DAVID RAMON were conducted with conscious disregard for the health, safety and welfare of Erick de Anda, and were therefore malicious, wanton, and oppressive. As a result, said defendants' actions justify an award of exemplary and punitive damages to punish the wrongful conduct alleged herein and to deter such conduct in the future.

### **EIGHTH CLAIM FOR RELIEF**

#### **State Civil Rights Violations**

**(Survival Action - California Civil Code § 52.1)**

**As Against All Defendants and DOES 1 through 10**

138. Plaintiff Erick de Anda realleges and incorporates the foregoing paragraphs as if set forth herein.

139. Plaintiff is informed and believes and thereon allege that while decedent Erick De Anda was under the sole exclusive care of Defendants, as described herein, and in Defendants' custody, he was suffering from a medical and mental health

condition which entitled him to the full and equal accommodations, advantages, facilities, privileges, or services for his condition.

140. Defendants acting within the scope and course of their employment and/or their contractual agreements with Defendant COUNTY OF MONTEREY, had a duty to provide decedent Erick de Anda medical and mental health accommodation, advantages, facilities, privileges, or services for his condition, and violated said statutory mandates herein. The conduct of County and CFMG Defendants, as described herein, acting in the course and scope of their employment and/or contractual agreements for County and CFMG Defendants, violated California Civil Code Section 52.1, they interfered with Plaintiffs' decedent's exercise and enjoyment of his civil rights, Erick de Anda died, and Plaintiffs have suffered damages as set forth herein.

141. As a direct and proximate result of Defendants' violation of Civil Code §52.1, decedent suffered violation of his constitutional rights, and suffered damages as set forth herein.

142. Because this conduct occurred in the course and scope of their employment, Defendants COUNTY OF MONTEREY and CFMG is therefore liable to Plaintiffs pursuant to *respondeat superior*.

### **PRAYER FOR RELIEF**

**WHEREFORE**, Plaintiffs pray for the following relief:

1. For compensatory, general and special damages against each Defendant, jointly and severally, in an amount to be proven at trial;
2. For damages related to loss of familial relation as to Plaintiff Enrique de Anda Garcia;
3. Funeral and burial expenses, and incidental expenses not yet fully ascertained;

- 1       4. General damages, including damages for physical and emotional pain,
- 2       emotional distress, hardship, suffering, shock, worry, anxiety, sleeplessness,
- 3       illness and trauma and suffering, the loss of the services, society, care and
- 4       protection of the decedent, as well as the loss of financial support and
- 5       contributions, loss of the present value of future services and contributions,
- 6       and loss of economic security;
- 7       5. Prejudgment interest;
- 8       6. For punitive and exemplary damages against RAYMOND HERR,
- 9       TAYLOR FITHIAN, KIP HALLMAN, MARIANNE ROWE,
- 10       ELIZABETH FALCON, CINDY WATSON, YVONNE MAXFIELD,
- 11       JODEL JENCKS, CALIFORNIA FORENSIC MEDICAL GROUP, INC.,
- 12       STEVE BERNAL, JOHN MIHU, JAMES BASS, DAVID COOPER, and
- 13       DAVID RAMON, in an amount sufficient and appropriate to punish each
- 14       said defendant and deter others from engaging in similar misconduct;
- 15       7. For costs of suit and reasonable attorneys' fees and costs pursuant to 42
- 16       U.S.C. § 1988, and as otherwise authorized by statute or law;
- 17       8. For violation of California Civil Code §52 and 52.1, statutory damages, and
- 18       reasonable attorney's fees;
- 19       9. For violation of California Civil Code § 51.7 pursuant to California Civil
- 20       Code § 52(b), punitive damages against Defendant peace officers;
- 21       10. For restitution as the court deems just and proper;

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1 11. For such other relief, including injunctive and/or declaratory relief, as the  
2 Court may deem proper.

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4 Dated: September 12, 2017

CASILLAS & ASSOCIATES

5 By \_\_\_\_\_

6 ARNOLDO CASILLAS

7 DENISSE O. GASTÉLUM

8 Attorneys for Plaintiffs,

9 ESTATE OF ERICK DE ANDA, by and  
10 through successor in interest, Enrique de Anda  
11 Garcia; ENRIQUE DE ANDA GARCIA,  
12 individually

**DEMAND FOR JURY TRIAL**

Plaintiffs ESTATE OF ERICK DE ANDA, by and through successor in interest, ENRIQUE DE ANDA GARCIA, ENRIQUE DE ANDA GARCIA, individually, hereby demand trial by jury.

Dated: September 12, 2017

CASILLAS & ASSOCIATES

By \_\_\_\_\_  
ARNOLDO CASILLAS  
DENISSE O. GASTÉLUM  
Attorneys for Plaintiffs,  
ESTATE OF ERICK DE ANDA, by and  
through successor in interest, Enrique de Anda  
Garcia; ENRIQUE DE ANDA GARCIA,  
individually